## KENTUCKY BOARD OF PHARMACY

## **Internship Report**

Name _	(Last)			(First)		Pharmacy Intern No						
I shall re	esume my	pharmac <sub>y</sub>	y educatior	at and here	eby apply f					ersity elow		
					(P		cist Preceptor	r)				
at			(N	ame and Addre	ess of Pharmacy	)						
							(Sign	nature)				
Week Ending			Number			Week Ending Number						
Month	Day	Year	of Hours	$\mathbf{E}^*$	Mon	Month Day			of Hours	$\mathbf{E}^*$		
I hereby from the	certify th	nat this re of the abo		orrect sta	tement of f and is ava		e for exa	mination	by the Ker			
	(Signature of Preceptor)											
for all in	ternship	experienc		the prece	submitted ding twelve 0601-9230.							
				(For O	ffice Use)							
			Hours Enrolled									
	Total Hou	ırs Internsh	ip Credited									
Remarks:												
Date					Approved							

## FOR INTERNSHIP OUTSIDE OF KENTUCKY

The Pharmacist Preceptor and Pharmacy named in the preceding report are currently in good standing with this Board.

Date	By						
(Seal)	Title						
	Board of Pharmacy						
(The above must be completed by an official of the Board of Pharmacy in the state where internship was obtained.)							